



Reprinted
February 27, 2003

HOUSE BILL No. 1749

DIGEST OF HB 1749 (Updated February 26, 2003 2:59 PM - DI 97)

Citations Affected: IC 2-5; IC 27-8; noncode.

Synopsis: Health insurance. Amends the comprehensive health insurance association (ICHIA) law concerning eligibility, reimbursement, prescription drug coverage, chronic disease management, and termination of coverage. Specifies certain requirements that must be contained in another state's law concerning association group accident and sickness insurance policies if a policy issued in the other state covers an Indiana resident. Makes conforming and technical amendments.

Effective: July 1, 2003.

Fry, Ripley

January 21, 2003, read first time and referred to Committee on Insurance, Corporations and Small Business.
February 20, 2003, amended, reported — Do Pass.
February 26, 2003, read second time, amended, ordered engrossed.

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HB 1749—LS 6720/DI 97+



Reprinted
February 27, 2003

First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

HOUSE BILL No. 1749

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

- 1 SECTION 1. IC 2-5-23-8 IS AMENDED TO READ AS FOLLOWS
2 [EFFECTIVE JULY 1, 2003]: Sec. 8. Beginning May 1, 1997, the
3 health policy advisory committee is established. At the request of the
4 chairman, the health policy advisory committee shall provide
5 information and otherwise assist the commission to perform the duties
6 of the commission under this chapter. The health policy advisory
7 committee members are ex officio and may not vote. The health policy
8 advisory committee members shall be appointed from the general
9 public and must include one (1) individual who represents each of the
10 following:
11 (1) The interests of public hospitals.
12 (2) The interests of community mental health centers.
13 (3) The interests of community health centers.
14 (4) The interests of the long term care industry.
15 (5) The interests of health care professionals licensed under
16 IC 25, but not licensed under IC 25-22.5.
17 (6) The interests of rural hospitals. An individual appointed under

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1 this subdivision must be licensed under IC 25-22.5.

2 (7) The interests of health maintenance organizations (as defined
3 in IC 27-13-1-19).

4 (8) The interests of for-profit health care facilities (as defined in
5 ~~IC 27-8-10-1(1)~~; **IC 27-8-10-1**).

6 (9) A statewide consumer organization.

7 (10) A statewide senior citizen organization.

8 (11) A statewide organization representing people with
9 disabilities.

10 (12) Organized labor.

11 (13) The interests of businesses that purchase health insurance
12 policies.

13 (14) The interests of businesses that provide employee welfare
14 benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.

15 (15) A minority community.

16 (16) The uninsured. An individual appointed under this
17 subdivision must be and must have been chronically uninsured.

18 (17) An individual who is not associated with any organization,
19 business, or profession represented in this subsection other than
20 as a consumer.

21 SECTION 2. IC 27-8-5-16.5, AS AMENDED BY P.L.96-2002,
22 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
23 JULY 1, 2003]: Sec. 16.5. (a) As used in this section, "delivery state"
24 means any state other than Indiana in which a policy is delivered or
25 issued for delivery.

26 (b) Except as provided in subsection (c), (d), or (e), a certificate may
27 not be issued to a resident of Indiana pursuant to a group policy that is
28 delivered or issued for delivery in a state other than Indiana.

29 (c) A certificate may be issued to a resident of Indiana pursuant to
30 a group policy not described in subsection (d) that is delivered or
31 issued for delivery in a state other than Indiana if:

32 (1) the delivery state has a law substantially similar to section 16
33 of this chapter;

34 (2) the delivery state has approved the group policy; and

35 (3) the policy or the certificate contains provisions that are:

36 (A) substantially similar to the provisions required by:

37 (i) section 19 of this chapter;

38 (ii) section 21 of this chapter; and

39 (iii) IC 27-8-5.6; and

40 (B) consistent with the requirements set forth in:

41 (i) section 24 of this chapter;

42 (ii) IC 27-8-6;



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- (iii) IC 27-8-14;
- (iv) IC 27-8-23;
- (v) 760 IAC 1-38.1; and
- (vi) 760 IAC 1-39.

(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust group policy that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter, **including the requirements that apply to association groups, particularly the requirement that the association must be organized and maintained in good faith for purposes other than obtaining insurance;**

(2) the delivery state has approved the group policy; and

(3) the policy or the certificate contains provisions that are:

(A) substantially similar to the provisions required by:

- (i) section 19 of this chapter;
- (ii) section 21 of this chapter; and
- (iii) IC 27-8-5.6; and

(B) consistent with the requirements set forth in:

- (i) section 15.6 of this chapter;
- (ii) section 24 of this chapter;
- (iii) section 26 of this chapter;
- (iv) IC 27-8-6;
- (v) IC 27-8-14;
- (vi) IC 27-8-14.1;
- (vii) IC 27-8-14.5;
- (viii) IC 27-8-14.7;
- (ix) IC 27-8-14.8;
- (x) IC 27-8-20;
- (xi) IC 27-8-23;
- (xii) IC 27-8-24.3;
- (xiii) IC 27-8-26;
- (xiv) IC 27-8-28;
- (xv) IC 27-8-29;
- (xvi) 760 IAC 1-38.1; and
- (xvii) 760 IAC 1-39.

(e) A certificate may be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana if the commissioner determines that the policy pursuant to which the certificate is issued meets the requirements set forth in section 17(a) of this chapter.



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(f) This section does not affect any other provision of Indiana law governing the terms or benefits of coverage provided to a resident of Indiana under any certificate or policy of insurance.

SECTION 3. IC 27-8-10-1, AS AMENDED BY P.L.1-2001, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association that provides coverage specified in section 3 of this chapter. The term does not include a Medicare supplement policy that is issued under section 9 of this chapter.

(d) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.

(e) "Church plan" means a plan defined in the federal Employee Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).

(f) "Commissioner" refers to the insurance commissioner.

(g) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) "Federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

- (A) group health plan;
- (B) governmental plan; or
- (C) church plan;

or health insurance coverage in connection with any of these plans;

(2) who is not eligible for coverage under:

- (A) a group health plan;
- (B) Part A or Part B of Title XVIII of the federal Social Security Act; or
- (C) a state plan under Title XIX of the federal Social Security Act (or any successor program);

and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of

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1 premiums or fraud;

2 (4) who, if after being offered the option of continuation coverage
3 under the Consolidated Omnibus Budget Reconciliation Act of
4 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state
5 program, elected such coverage; and

6 (5) who, if after electing continuation coverage described in
7 subdivision (4), has exhausted continuation coverage under the
8 provision or program.

9 (j) "Governmental plan" means a plan as defined under the federal
10 Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d))
11 and any plan established or maintained for its employees by the United
12 States government or by any agency or instrumentality of the United
13 States government.

14 (k) "Group health plan" means an employee welfare benefit plan (as
15 defined in 29 U.S.C. 1167(1)) to the extent that the plan provides
16 medical care payments to, or on behalf of, employees or their
17 dependents, as defined under the terms of the plan, directly or through
18 insurance, reimbursement, or otherwise.

19 (l) "Health care facility" means any institution providing health care
20 services that is licensed in this state, including institutions engaged
21 principally in providing services for health maintenance organizations
22 or for the diagnosis or treatment of human disease, pain, injury,
23 deformity, or physical condition, including a general hospital, special
24 hospital, mental hospital, public health center, diagnostic center,
25 treatment center, rehabilitation center, extended care facility, skilled
26 nursing home, nursing home, intermediate care facility, tuberculosis
27 hospital, chronic disease hospital, maternity hospital, outpatient clinic,
28 home health care agency, bioanalytical laboratory, or central services
29 facility servicing one (1) or more such institutions.

30 (m) "Health care institutions" means skilled nursing facilities, home
31 health agencies, and hospitals.

32 (n) "Health care provider" means any physician, hospital,
33 pharmacist, or other person who is licensed in Indiana to furnish health
34 care services.

35 (o) "Health care services" means any services or products included
36 in the furnishing to any individual of medical care, dental care, or
37 hospitalization, or incident to the furnishing of such care or
38 hospitalization, as well as the furnishing to any person of any other
39 services or products for the purpose of preventing, alleviating, curing,
40 or healing human illness or injury.

41 (p) "Health insurance" means hospital, surgical, and medical
42 expense incurred policies, nonprofit service plan contracts, health

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1 maintenance organizations, limited service health maintenance
 2 organizations, and self-insured plans. However, the term "health
 3 insurance" does not include short term travel accident policies,
 4 accident only policies, fixed indemnity policies, automobile medical
 5 payment, or incidental coverage issued with or as a supplement to
 6 liability insurance.

7 (q) "Insured" means all individuals who are provided qualified
 8 comprehensive health insurance coverage under an individual policy,
 9 including all dependents and other insured persons, if any.

10 (r) "Medicaid" means medical assistance provided by the state under
 11 the Medicaid program under IC 12-15.

12 (s) "Medical care payment" means amounts paid for:

13 (1) the diagnosis, care, mitigation, treatment, or prevention of
 14 disease or amounts paid for the purpose of affecting any structure
 15 or function of the body;

16 (2) transportation primarily for and essential to Medicare services
 17 referred to in subdivision (1); and

18 (3) insurance covering medical care referred to in subdivisions (1)
 19 and (2).

20 (t) "Medically necessary" means health care services that the
 21 association has determined:

22 (1) are recommended by a legally qualified physician;

23 (2) are commonly and customarily recognized throughout the
 24 physician's profession as appropriate in the treatment of the
 25 patient's diagnosed illness; and

26 (3) are not primarily for the scholastic education or vocational
 27 training of the provider or patient.

28 (u) "Medicare" means Title XVIII of the federal Social Security Act
 29 (42 U.S.C. 1395 et seq.).

30 (v) "Policy" means a contract, policy, or plan of health insurance.

31 (w) "Policy year" means a twelve (12) month period during which
 32 a policy provides coverage or obligates the carrier to provide health
 33 care services.

34 (x) "Health maintenance organization" has the meaning set out in
 35 IC 27-13-1-19.

36 (y) **"Resident" means an individual who is:**

37 **(1) legally domiciled in Indiana for at least one hundred**
 38 **eighty (180) days before applying for an association policy; or**

39 **(2) a federally eligible individual and legally domiciled in**
 40 **Indiana.**

41 (z) "Self-insurer" means an employer who provides services,
 42 payment for, or reimbursement of any part of the cost of health care

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services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

~~(z)~~ **(aa)** "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

~~(aa)~~ **(bb)** "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

~~(bb)~~ **(cc)** "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.

~~(cc)~~ **(dd)** "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

SECTION 4. IC 27-8-10-2.1, AS AMENDED BY P.L. 192-2002(ss), SECTION 169, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of seven (7) members whose principal residence is in Indiana selected as follows:

(1) Three (3) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

The commissioner shall appoint the chairman of the board, and the



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board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

- (1) establish procedures for the handling and accounting of assets and money of the association;
- (2) establish the amount and method of reimbursing members of the board;
- (3) establish regular times and places for meetings of the board of directors;
- (4) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;
- (5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;
- (6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and
- (7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the



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1 association.

2 (d) The plan of operation may provide that any of the powers and
3 duties of the association be delegated to a person who will perform
4 functions similar to those of this association. A delegation under this
5 section takes effect only with the approval of both the board of
6 directors and the commissioner. The commissioner may not approve a
7 delegation unless the protections afforded to the insured are
8 substantially equivalent to or greater than those provided under this
9 chapter.

10 (e) The association has the general powers and authority enumerated
11 by this subsection in accordance with the plan of operation approved
12 by the commissioner under subsection (c). The association has the
13 general powers and authority granted under the laws of Indiana to
14 carriers licensed to transact the kinds of health care services or health
15 insurance described in section 1 of this chapter and also has the
16 specific authority to do the following:

- 17 (1) Enter into contracts as are necessary or proper to carry out this
18 chapter, subject to the approval of the commissioner.
- 19 (2) Sue or be sued, including taking any legal actions necessary
20 or proper for recovery of any assessments for, on behalf of, or
21 against participating carriers.
- 22 (3) Take legal action necessary to avoid the payment of improper
23 claims against the association or the coverage provided by or
24 through the association.
- 25 (4) Establish a medical review committee to determine the
26 reasonably appropriate level and extent of health care services in
27 each instance.
- 28 (5) Establish appropriate rates, scales of rates, rate classifications
29 and rating adjustments, such rates not to be unreasonable in
30 relation to the coverage provided and the reasonable operational
31 expenses of the association.
- 32 (6) Pool risks among members.
- 33 (7) Issue policies of insurance on an indemnity or provision of
34 service basis providing the coverage required by this chapter.
- 35 (8) Administer separate pools, separate accounts, or other plans
36 or arrangements considered appropriate for separate members or
37 groups of members.
- 38 (9) Operate and administer any combination of plans, pools, or
39 other mechanisms considered appropriate to best accomplish the
40 fair and equitable operation of the association.
- 41 (10) Appoint from among members appropriate legal, actuarial,
42 and other committees as necessary to provide technical assistance



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in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association. ~~and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.~~

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may not be more than one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Any net loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation. For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding



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1 claims for Medicaid contracts with the state of Indiana, or the value of
 2 services provided. In sharing losses, the association may abate or defer
 3 in any part the assessment of a member, if, in the opinion of the board,
 4 payment of the assessment would endanger the ability of the member
 5 to fulfill its contractual obligations. The association may also provide
 6 for interim assessments against members of the association if necessary
 7 to assure the financial capability of the association to meet the incurred
 8 or estimated claims expenses or operating expenses of the association
 9 until the association's next fiscal year is completed. Net gains, if any,
 10 must be held at interest to offset future losses or allocated to reduce
 11 future premiums. Assessments must be determined by the board
 12 members specified in subsection (b)(1), subject to final approval by the
 13 commissioner.

14 (h) The association shall conduct periodic audits to assure the
 15 general accuracy of the financial data submitted to the association, and
 16 the association shall have an annual audit of its operations by an
 17 independent certified public accountant.

18 (i) The association is subject to examination by the department of
 19 insurance under IC 27-1-3.1. The board of directors shall submit, not
 20 later than March 30 of each year, a financial report for the preceding
 21 calendar year in a form approved by the commissioner.

22 (j) All policy forms issued by the association must conform in
 23 substance to prototype forms developed by the association, must in all
 24 other respects conform to the requirements of this chapter, and must be
 25 filed with and approved by the commissioner before their use.

26 (k) The association may not issue an association policy to any
 27 individual who, on the effective date of the coverage applied for, does
 28 not meet the eligibility requirements of section 5.1 of this chapter.

29 ~~(h) The association shall pay an agent's referral fee of twenty-five~~
 30 ~~dollars (\$25) to each insurance agent who refers an applicant to the~~
 31 ~~association if that applicant is accepted.~~

32 ~~(m)(l)~~ (l) The association and the premium collected by the association
 33 shall be exempt from the premium tax, the adjusted gross income tax,
 34 or any combination of these upon revenues or income that may be
 35 imposed by the state.

36 ~~(m)~~ (m) Members who after July 1, 1983, during any calendar year,
 37 have paid one (1) or more assessments levied under this chapter may
 38 either:

39 (1) take a credit against premium taxes, adjusted gross income
 40 taxes, or any combination of these, or similar taxes upon revenues
 41 or income of member insurers that may be imposed by the state,
 42 up to the amount of the taxes due for each calendar year in which

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the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by either credits against those taxes or refunds from the association; or

(2) any member insurer may include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

~~(n)~~ (n) The association shall provide for the option of monthly collection of premiums.

SECTION 5. IC 27-8-10-2.3, AS ADDED BY P.L.167-2002, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 2.3. A member shall, not later than October 31 of each year, certify an independently audited report to the:

- (1) association;
- (2) legislative council; and
- (3) department of insurance;

of the amount of tax credits taken against assessments by the member under section ~~2.1(n)(1)~~ **2.1(m)(1)** of this chapter during the previous calendar year.

SECTION 6. IC 27-8-10-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 3. (a) An association policy issued under this chapter may pay usual and customary charges or use other reimbursement systems that are consistent with managed care plans, including fixed fee schedules and capitated reimbursement, for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter. **However, the amount of reimbursement for a health care service covered under an association policy may not exceed the amount of reimbursement for the same health care service under Medicare.**

(b) Eligible expenses are the charges for the following health care services and articles to the extent furnished by a health care provider in an emergency situation or furnished or prescribed by a physician:

- (1) Hospital services, including charges for the institution's most common semiprivate room, and for private room only when medically necessary, but limited to a total of one hundred eighty (180) days in a year.
- (2) Professional services for the diagnosis or treatment of injuries,



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1 illnesses, or conditions, other than mental or dental, that are
 2 rendered by a physician or, at the physician's direction, by the
 3 physician's staff of registered or licensed nurses, and allied health
 4 professionals.

5 (3) The first twenty (20) professional visits for the diagnosis or
 6 treatment of one (1) or more mental conditions rendered during
 7 the year by one (1) or more physicians or, at their direction, by
 8 their staff of registered or licensed nurses, and allied health
 9 professionals.

10 (4) Drugs and contraceptive devices requiring a physician's
 11 prescription.

12 (5) Services of a skilled nursing facility for not more than one
 13 hundred eighty (180) days in a year.

14 (6) Services of a home health agency up to two hundred seventy
 15 (270) days of service a year.

16 (7) Use of radium or other radioactive materials.

17 (8) Oxygen.

18 (9) Anesthetics.

19 (10) Prostheses, other than dental.

20 (11) Rental of durable medical equipment which has no personal
 21 use in the absence of the condition for which prescribed.

22 (12) Diagnostic X-rays and laboratory tests.

23 (13) Oral surgery for:

24 (A) excision of partially or completely erupted impacted teeth;

25 (B) excision of a tooth root without the extraction of the entire
 26 tooth; or

27 (C) the gums and tissues of the mouth when not performed in
 28 connection with the extraction or repair of teeth.

29 (14) Services of a physical therapist and services of a speech
 30 therapist.

31 (15) Professional ambulance services to the nearest health care
 32 facility qualified to treat the illness or injury.

33 (16) Other medical supplies required by a physician's orders.

34 An association policy may also include comparable benefits for those
 35 who rely upon spiritual means through prayer alone for healing upon
 36 such conditions, limitations, and requirements as may be determined
 37 by the board of directors.

38 ~~(b)~~ (c) A managed care organization that issues an association
 39 policy may not refuse to enter into an agreement with a hospital solely
 40 because the hospital has not obtained accreditation from an
 41 accreditation organization that:

42 (1) establishes standards for the organization and operation of



hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

~~(c)~~ (d) This section does not prohibit a managed care organization from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

~~(d)~~ (e) For purposes of this section, if benefits are provided in the form of services rather than cash payments, their value shall be determined on the basis of their monetary equivalency.

~~(e)~~ (f) The following are not eligible expenses in any association policy within the scope of this chapter:

(1) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(2) Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens by the United States.

(3) Benefits which would duplicate the provision of services or payment of charges for any care for injury or disease either:

(A) arising out of and in the course of an employment subject to a worker's compensation or similar law; or

(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance.

However, this subdivision does not authorize exclusion of charges that exceed the benefits payable under the applicable worker's compensation or no-fault coverage.

(4) Care which is primarily for a custodial or domiciliary purpose.

(5) Cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure.

(6) Any charge for services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

~~(f)~~ (g) The coverage and benefit requirements of this section for

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association policies may not be altered by any other inconsistent state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

~~(g)~~ **(h)** This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board of directors, may be of benefit to the citizens of Indiana.

~~(h)~~ **(i)** This chapter does not prohibit the association or its administrator from implementing uniform procedures to review the medical necessity and cost effectiveness of proposed treatment, confinement, tests, or other medical procedures. Those procedures may take the form of preadmission review for nonemergency hospitalization, case management review to verify that covered individuals are aware of treatment alternatives, or other forms of utilization review. Any cost containment techniques of this type must be adopted by the board of directors and approved by the commissioner.

SECTION 7. IC 27-8-10-3.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: **Sec. 3.5. (a) The association shall:**

(1) use the Medicaid preferred drug list developed under IC 12-15-35, except that a prescription drug prescribed for the treatment of human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or hemophilia may not be placed on prior authorization; and

(2) implement a copayment structure; for prescription drugs covered under an association policy.
(b) The copayment structure implemented under subsection (a) must be based on an annual actuarial analysis.

SECTION 8. IC 27-8-10-3.6 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: **Sec. 3.6. (a) The association shall:**

(1) establish a list of chronic diseases; and
(2) approve disease management programs for management of chronic diseases listed under subdivision (1).

(b) A disease management program for which federal funding is available is considered to be approved by the association under this section.

(c) An insured who has a chronic disease for which at least one (1) chronic disease management program is approved under this section shall participate in an approved chronic disease management program for the chronic disease as a condition of



1 coverage of treatment for the chronic disease under an association
2 policy.

3 SECTION 9. IC 27-8-10-3.7 IS ADDED TO THE INDIANA CODE
4 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
5 1, 2003]: Sec. 3.7. (a) The association shall approve a mail order or
6 Internet based pharmacy (as defined in IC 25-26-18-1) through
7 which an insured may obtain prescription drugs covered under an
8 association policy.

9 (b) A prescription drug that is covered under an association
10 policy is covered if the prescription drug is obtained from:

11 (1) a pharmacy approved under subsection (a); or

12 (2) a pharmacy that:

13 (A) is not approved under subsection (a); and

14 (B) agrees to sell the prescription drug at the same price as
15 a pharmacy approved under subsection (a).

16 (c) A prescription drug that is:

17 (1) covered under an association policy; and

18 (2) obtained from a pharmacy not described in subsection (b);
19 is covered for an amount equal to the price at which a pharmacy
20 described in subsection (b) will sell the prescription drug, with the
21 remainder of the charge for the prescription drug to be paid by the
22 insured.

23 SECTION 10. IC 27-8-10-5.1, AS AMENDED BY P.L.233-1999,
24 SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
25 JULY 1, 2003]: Sec. 5.1. (a) A person is not eligible for an
26 association policy if the person is eligible for Medicaid.

27 (b) Except as provided in subsections ~~(b)~~ (c) and ~~(c)~~ (d), a person
28 is not eligible for an association policy if, at the effective date of
29 coverage, the person has or is eligible for coverage under any insurance
30 plan that equals or exceeds the minimum requirements for accident and
31 sickness insurance policies issued in Indiana as set forth in IC 27.
32 Coverage under any association policy is in excess of, and may not
33 duplicate, coverage under any other form of health insurance.

34 ~~(b)~~ (c) Except as provided in IC 27-13-16-4 and subsection (a), a
35 person is eligible for an association policy upon a showing that:

36 (1) the person has been rejected by one (1) carrier for coverage
37 under any insurance plan that equals or exceeds the minimum
38 requirements for accident and sickness insurance policies issued
39 in Indiana, as set forth in IC 27, without material underwriting
40 restrictions;

41 (2) an insurer has refused to issue insurance except at a rate
42 exceeding the association plan rate; or



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(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(c) The board of directors may establish procedures that would permit:

- (1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and
- (2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.

(d) Coverage under an association policy terminates as follows:

- (1) On the first date on which an insured is no longer a resident of Indiana.
- (2) On the date on which an insured requests cancellation of the association policy.
- (3) On the date of the death of an insured.
- (4) At the end of the policy period for which the premium has been paid.
- (5) On the first date on which the insured no longer meets the eligibility requirements under this section.

(e) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full-time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

- (1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and
- (2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(f) An association policy that provides coverage for a family



1 member of the person in whose name the contract is issued must, as to
 2 the family member's coverage, also provide that the health insurance
 3 benefits applicable for children are payable with respect to a newly
 4 born child of the person in whose name the contract is issued from the
 5 moment of birth. The coverage for newly born children must consist of
 6 coverage of injury or illness, including the necessary care and treatment
 7 of medically diagnosed congenital defects and birth abnormalities. If
 8 payment of a specific premium is required to provide coverage for the
 9 child, the contract may require that notification of the birth of a child
 10 and payment of the required premium must be furnished to the carrier
 11 within thirty-one (31) days after the date of birth in order to have the
 12 coverage continued beyond the thirty-one (31) day period.

13 ~~(f)~~ **(g)** Except as provided in subsection ~~(g)~~; **(h)**, an association
 14 policy may contain provisions under which coverage is excluded
 15 during a period of three (3) months following the effective date of
 16 coverage as to a given covered individual for preexisting conditions, as
 17 long as medical advice or treatment was recommended or received
 18 within a period of three (3) months before the effective date of
 19 coverage. This subsection may not be construed to prohibit preexisting
 20 condition provisions in an insurance policy that are more favorable to
 21 the insured.

22 ~~(g)~~ **(h)** If a person applies for an association policy within six (6)
 23 months after termination of the person's coverage under a health
 24 insurance arrangement and the person meets the eligibility
 25 requirements of subsection ~~(b)~~; **(c)**, then an association policy may not
 26 contain provisions under which:

27 (1) coverage as to a given individual is delayed to a date after the
 28 effective date or excluded from the policy; or

29 (2) coverage as to a given condition is denied;

30 on the basis of a preexisting health condition. This subsection may not
 31 be construed to prohibit preexisting condition provisions in an
 32 insurance policy that are more favorable to the insured.

33 ~~(h)~~ **(i)** For purposes of this section, coverage under a health
 34 insurance arrangement includes, but is not limited to, coverage
 35 pursuant to the Consolidated Omnibus Budget Reconciliation Act of
 36 1985.

37 SECTION 11. IC 27-8-10-6 IS AMENDED TO READ AS
 38 FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 6. (a) An association
 39 policy offered under this chapter must contain provisions under which
 40 the association is obligated to renew the contract until:

41 **(1) the date on which coverage terminates under section 5.1 of**
 42 **this chapter; or**



(2) the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the durational requirement of this ~~subsection~~ **subdivision**.

(b) The association may not change the rates for association policies or Medicare supplement policies except on a class basis with a clear disclosure in the policy of the association's right to do so.

(c) An association policy offered under this chapter must provide that upon the death of the individual in whose name the contract is issued, every other individual then covered under the contract may elect, within a period specified in the contract, to continue coverage under the same or a different contract until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived.

SECTION 12. IC 27-8-10-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 10. Before January 1, 1996, the board of directors of the association shall establish eligibility guidelines for the issuance of an association policy under this chapter to prohibit an:

- (1) employer;
- (2) insurance ~~agent~~ **producer**; or
- (3) insurance broker;

from placing in or referring to the association an individual who works for an employer who offers employees an employee welfare benefit plan (as defined in 29 U.S.C. 1002).

SECTION 13. [EFFECTIVE JULY 1, 2003] (a) IC 27-8-10-3.5, IC 27-8-10-3.6, and IC 27-8-10-3.7, all as added by this act, and IC 27-8-10-4, IC 27-8-10-5.1, and IC 27-8-10-6, all as amended by this act, apply to an association policy that is issued, delivered, amended, or renewed after June 30, 2003.

(b) If the amount of reimbursement for health care services covered under an Indiana comprehensive health insurance association policy is specified under a contract with a health care provider, IC 27-8-10-3, as amended by this act, applies to a contract specifying the amount of reimbursement for health care services that is entered into, delivered, amended, or renewed after June 30, 2003.

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1749, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete everything after the enacting clause, begin a new paragraph

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB1749 as introduced.)

FRY, Chair

Committee Vote: yeas 12, nays 0.

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1749 be amended to read as follows:

Page 2, between lines 20 and 21, begin a new paragraph and insert:
 "SECTION 2. IC 27-8-5-16.5, AS AMENDED BY P.L.96-2002, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 16.5. (a) As used in this section, "delivery state" means any state other than Indiana in which a policy is delivered or issued for delivery.

(b) Except as provided in subsection (c), (d), or (e), a certificate may not be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana.

(c) A certificate may be issued to a resident of Indiana pursuant to a group policy not described in subsection (d) that is delivered or issued for delivery in a state other than Indiana if:

- (1) the delivery state has a law substantially similar to section 16 of this chapter;
- (2) the delivery state has approved the group policy; and
- (3) the policy or the certificate contains provisions that are:
 - (A) substantially similar to the provisions required by:
 - (i) section 19 of this chapter;
 - (ii) section 21 of this chapter; and
 - (iii) IC 27-8-5.6; and
 - (B) consistent with the requirements set forth in:
 - (i) section 24 of this chapter;
 - (ii) IC 27-8-6;
 - (iii) IC 27-8-14;
 - (iv) IC 27-8-23;
 - (v) 760 IAC 1-38.1; and
 - (vi) 760 IAC 1-39.

(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust group policy that is delivered or issued for delivery in a state other than Indiana if:

- (1) the delivery state has a law substantially similar to section 16 of this chapter, **including the requirements that apply to association groups, particularly the requirement that the association must be organized and maintained in good faith for purposes other than obtaining insurance;**
- (2) the delivery state has approved the group policy; and
- (3) the policy or the certificate contains provisions that are:
 - (A) substantially similar to the provisions required by:

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- (i) section 19 of this chapter;
 - (ii) section 21 of this chapter; and
 - (iii) IC 27-8-5.6; and
- (B) consistent with the requirements set forth in:
- (i) section 15.6 of this chapter;
 - (ii) section 24 of this chapter;
 - (iii) section 26 of this chapter;
 - (iv) IC 27-8-6;
 - (v) IC 27-8-14;
 - (vi) IC 27-8-14.1;
 - (vii) IC 27-8-14.5;
 - (viii) IC 27-8-14.7;
 - (ix) IC 27-8-14.8;
 - (x) IC 27-8-20;
 - (xi) IC 27-8-23;
 - (xii) IC 27-8-24.3;
 - (xiii) IC 27-8-26;
 - (xiv) IC 27-8-28;
 - (xv) IC 27-8-29;
 - (xvi) 760 IAC 1-38.1; and
 - (xvii) 760 IAC 1-39.

(e) A certificate may be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana if the commissioner determines that the policy pursuant to which the certificate is issued meets the requirements set forth in section 17(a) of this chapter.

(f) This section does not affect any other provision of Indiana law governing the terms or benefits of coverage provided to a resident of Indiana under any certificate or policy of insurance."

Page 9, line 12, after "association" delete ".".

Renumber all SECTIONS consecutively.

(Reference is to HB 1749 as printed February 21, 2003.)

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